STATE OF MICHIGAN

DEPARTMENT OF MANAGEMENT AND BUDGET

OFFICE OF RETIREMENT SERVICES

Serving the Customers of the Judges, Public School Employees, State Employees, and State Police Retirement Systems

PO Box 30171, Lansing, MI 48909-7671 www.michigan.gov/ors

Telephone: 517-322-5103 Outside Lansing: 800-381-5111

OFFICE USE ONLY		
RETIREE EFFECTIVE DATE		
MO	DAY	YR
H		
VBR		
DDR		

Group Insurance Application

Health, Vision, and Dental

PRINT AND COMPLETE ALL SPACES AS APPROPRIATE. Press hard. You are making five copies.

A. PENSION RECIPIENT DATA (This Section Must Be Completed)

SOCIAL SECURITY NUMBER	PLAN ADMINISTRATOR'S USE ONLY: GROUP NO. / SUFFIX / DEST. CODE	NO. OF MEM.	MAR. STAT	RELAT. SUB. / SP.

NAME: LAST	FIRST	MIDDLE	BIRTHDATE (MO DAY YR)	☐ MALE ☐ FEMALE

ADDRESS	CITY	STATE	ZIP CODE	PHONE
				- -

ARE YOU ENROLLED IN MEDICARE?	MEDICARE NO.	EFFECTIVE DATES FROM MEDICARE CARD: Hospital - Part A (MO DAY YR)	Medical - Part B (MO DAY YR)
YES ☐ NO ☐			

B. COVERAGE DATA (This Section Must Be Completed)

	ENROLL	DECLINE				
STATE HEALTH PLAN – BCBSM/PPO	☐	☐	☐ E - SELF	☐ S – SELF & SPOUSE	☐ C - SELF & CHILD(REN)	☐ **F - FULL FAMILY**
OTHER _____	☐	☐	**PLEASE OBTAIN AND ENCLOSE COMPLETED HMO APPLICATION**			
STATE VISION PLAN	☐	☐	☐ E - SELF	☐ S – SELF & SPOUSE	☐ C - SELF & CHILD(REN)	☐ F - FULL FAMILY
STATE DENTAL PLAN	☐	☐	☐ E - SELF	☐ S – SELF & SPOUSE	☐ C - SELF & CHILD(REN)	☐ F - FULL FAMILY

C. DEPENDENT DATA (Family Members You Are Covering).

LIST DEPENDENTS TO BE COVERED FOR THE INSURANCES CHECKED IN SECTION B. ATTACH ADDITIONAL PAGES IF NECESSARY.

	MEDICARE/SOCIAL SECURITY NUMBER	EFFECTIVE DATE FROM MEDICARE CARD: Hospital - Part A (MO DAY YR)	Medical - Part B (MO DAY YR)	SEX M/F	BIRTHDATE (MO DAY YR)
SPOUSE: NAME (Last, First, Middle)					
CHILD: NAME (Last, First, Middle)					
CHILD: NAME (Last, First, Middle)					
CHILD: NAME (Last, First, Middle)					

D. OTHER INSURANCE DATA (Complete When You Or Dependents Are Covered By Other Health Insurance)

ATTACH ADDITIONAL PAGES IF NECESSARY.

	POLICY HOLDER'S NAME	POLICY NUMBER	WHO IS COVERED?
NAME OF HEALTH INSURANCE COMPANY			☐ SPOUSE ☐ CHILD
NAME OF VISION INSURANCE COMPANY			☐ SPOUSE ☐ CHILD
NAME OF DENTAL INSURANCE COMPANY			☐ SPOUSE ☐ CHILD

I have read and agree to the applicable terms and conditions of this application as stated on the reverse side.

PENSION RECIPIENT'S SIGNATURE	DATE

Retain goldenrod copy for your records, then return this form to:

Office of Retirement Services • P.O. Box 30171 • Lansing, MI 48909-7671

R329M (Rev. 6/2002)
Authority, as amended: 1943 PA 240, 1992 PA 234
Protected information used for tax and actuarial purposes.
Completion of this form is voluntary.

WHITE – File Copy
GREEN – Health Plan Copy
CANARY – Dental Plan Copy
PINK – Vision Plan Copy
GOLDENROD – Retiree Copy

1) Enrollment

You must decide within 31 days after your pension effective date whether you will enroll in the insurance plans. If you choose not to enroll then, you may enroll later. If you enroll later, your coverage will begin six months following the first day of the month in which the Office of Retirement Services (ORS) receives your completed insurance application. For Blue Cross Blue Shield of Michigan/PPO, state vision plan and state dental plan insurance applications, call or write ORS. To enroll in any of the available HMOs, contact the appropriate HMO directly for an application to complete and return to the Office of Retirement Services with your retirement application.

The six-month waiting period can be waived if you enroll in this plan because you or your dependents lose eligibility for coverage in another group plan. Coverage can begin within 31 days after ORS receives your completed application along with a letter from the other group plan stating date of loss of coverage, why you are losing coverage and who was covered by the plan. You must notify ORS within 31 days of the loss of coverage to avoid the six-month waiting period.

2) Effective Date of Coverage

Medical, vision, and dental coverage always begins the first day of a calendar month. If you are a new retiree, you can begin coverage on the pension effective date or up to 90 days later. An approved application must be on file prior to the first of the month in which coverage is to begin.

Determining the correct effective date is very important and is your responsibility. ORS cannot provide premium refunds.

3) Coordination of Benefits (COB)

If both you and your spouse are state retirees and are enrolled in the same group plan, there will be no advantage for duplicating coverage because COB will not apply. You cannot cover your spouse if he or she is separately enrolled at the same time as an eligible state employee or state retiree.

4) Medicare

At age 65 or sooner if eligible (because of disability), you must enroll in Medicare health insurance (both hospital – Part A, and medical – Part B) through the Social Security Administration to maintain full benefit coverage. A copy of your Medicare card must be submitted to ORS.

5) By Signing the Front of This Form, I Agree to the Following Terms and Conditions:

I elect to enroll in the insurance plan(s) funded by the State Employees Retirement System for which I am or may become eligible, as indicated on the front side of this application, and authorize ORS to withhold the premiums required for the plan(s).

I agree that it is my responsibility to notify ORS of any changes in my status and that of my family that affects eligibility and/or coverage. I agree that should claims be paid on an ineligible individual, the costs of such claims may be deducted from future pension checks.

I authorize the administrator(s) identified by ORS to obtain from providers of service any and all records and other information relating to my covered family members and me. I understand that such information may be made available to ORS, on a confidential basis, for the purpose of evaluating the operation and efficiency of the plan(s) and providers. The duration of this authorization extends for the period of my coverage under the plan(s).

I certify that the information provided on the front side of this form is correct to the best of my information, knowledge, and belief.

I understand that when ORS accepts my application, my family members and I are bound by all conditions stated in the plan(s).

If I have declined coverage on the front of this form, I understand that I have been offered enrollment in the above plan but decline coverage at this time.

Retain the goldenrod copy of this form. Send the rest of the form to:
Office of Retirement Services, P.O. Box 30171, Lansing, MI 48909-7671